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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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HUMAN RESOURCES
DIVISION

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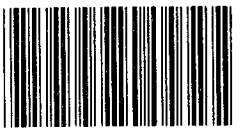
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Mr. Leonard Shaeffer
Administrator, Health Care
Financing Administration
Department of Health, Education
and Welfare
Washington, D.C.

AL-00624

D26-02024

Dear Mr. Schaeffer:

We recently completed a study of the Medicare and Medicaid billing systems currently in use at the Los Angeles County/University of Southern California Medical Center. This medical center was chosen as the focal point in our study because of its high volume of Medicare and Medicaid patients and its large expenditures for processing claims under these programs. Based on our study, we estimate that a substantial reduction in billing system costs could be achieved and passed on to the State and Federal Governments through the interchange of machine readable billing data and remittance advice between the Medical Center and the Medicare and Medicaid claims paying agents. Furthermore, we believe similar automation techniques would prove cost effective for many large health care providers throughout the Nation, and could collectively represent a worthwhile savings in the administrative costs incurred in submitting and processing claims under the Medicare and Medicaid programs.

Implementation of machine readable data exchange would reduce administration costs paid under the Medicare and Medicaid programs because

--providers could eliminate many clerical tasks associated with producing hard-copy billing documents and manually posting remittances to patient accounts; and

--State claims paying agents could decrease their data entry costs by reducing the need for manual entry of claim data to the processing system.

Group III Report

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While Medicare has recently taken action to implement automated billing systems wherever cost effective, Medicaid has no national guidelines in this area. A Medicaid Management Information System (MMIS) Task Force has been designated by the Health Care Financing Administration (HCFA) to develop new performance standards for States under the Medicaid program. We believe the standards should be developed with automated billing concepts in mind. We further believe that the Task Force should be used as a forum for presenting the benefits of the exchange of machine readable data and for pointing out how the use of this technique could assist States in meeting any performance standards relating to claims processing costs and timeliness.

POTENTIAL COST SAVINGS

Our analysis showed that the Medical Center spends approximately $3 million annually for salaries, equipment and supplies to operate its billing system. 1/ The system has the following workload.

Program	Number of Claims		
	Total	Inpatient	Outpatient
Medicare	45,400	7,200	38,200
Medicaid	144,100	34,200	109,900
Self Pay & Private Insurance	57,000	45,300	11,700
Total	246,500	86,700	159,800

About 72 percent of this cost can be attributed to Medicare and Medicaid claims. According to Medical Center officials, the billing system costs are included as a component of over-

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1/ The billing system is comprised primarily of four functions: (1) developing files of all documents necessary to bill for inpatient and outpatient services, (2) preparing, submitting, and filing claims to Medicare, Medicaid, health insurance companies, and/or patients, (3) preparing revenue reports, and (4) posting amounts received to the patients' accounts. The fourth function is called the account receivable subsystem of the Medical Center.

head expense and become part of the hospital's per diem costs for inpatients and per visit costs for outpatients. Thus, the Federal Government shares in part of the cost of the billing under Medicare and shares in part of the cost with the State on a 50/50 basis under Medicaid.

According to the Medical Center's Chief of Patient Accounts, implementation of a fully automated billing system would eliminate the clerical time now spent to manually produce claims and post remittance information to the patients' accounts upon receipt of payment. Assuming these manual tasks would be eliminated, our analysis showed that further automation techniques could reduce billing system costs by about $750,000 annually. The Federal share of the potential cost reductions would depend on how the reduction in the overhead cost area is allocated and apportioned to the Medicare and Medicaid programs on the institutions's cost reports, but we believe it would be about $300,000.

POTENTIAL REDUCTIONS IN COST AT THE MEDICAL CENTER FOR BILLING AND ACCOUNTS RECEIVABLE FUNCTIONS

Program	Fiscal Year 1979 Budgeted Cost	Estimated Cost Reduction Thru Automation
Medicare	$ 880,977	$275,650
Medicaid	1,341,534	473,953
Self Pay & Private Insurance	873,664	Not Estimated
Total	$3,096,172	$749,603

The estimated cost reductions may be offset to some extent by the need to handle exception cases due to special payment programs and human error. However, the officials we interviewed believed these costs would be minimal in comparison to the potential savings.

While automating the billing system of the Medical Center could result in significant savings, the potential for savings is greater if this billing concept is expanded to include all large health care providers in California and other States not using automated billing systems. For example, the University of California, San Francisco hospital is working on a pilot project developing and testing an auto-

mated Medicaid billing system. The hospital processes about half as many Medicare and Medicaid claims as the Medical Center. An official of the University working on this project estimated that the hospital could save between $50,000 and $60,000 annually through a fully automated Medicare and Medicaid billing system. The University of California , San Diego hospital processes about one third as many Medicare and Medicaid claims as the Medical Center and estimates an annual savings of $96,000 through full automation.

In our opinion, claims paying agents' costs would also be reduced by implementing a machine readable data exchange system. Currently the Medicare and Medicaid claims paying agents in California must manually enter large amounts of data from claims into their computer processing systems. If claims were received from providers in machine readable form, this step could be eliminated.

RECENT ACTION BY MEDICARE AND MEDICAID

Recognizing the benefits of automated billing, Medicare has recently taken steps to implement such systems between its providers and claims paying agents. In January 1979, HCFA issued a new procedure requiring that agents develop automated system capabilities to receive machine readable claims data from providers or their billing services in lieu of hardcopy data where it is determined to be cost-effective. 1/ Under the directive agents must carry out cost-benefit analyses for each provider to determine the cost-effectiveness of automated billing.

Unlike Medicare, the Medicaid program is administered by the States and States may need to modify their program requirements to allow providers to implement automated billing systems using machine readable data exchange. For example, California currently requires providers to attach "proof of eligibility" labels to Medicaid claims as a condition of payment. If claims without labels are received by the agents, they are denied payment and sent back to the provider. According to officials of HCFA Region IX, the labels are not machine readable and one effect of the label

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1/ Medicare Intermediary Manual Part A, Section 3602, Provider Submission of Machine Readable Claims Data

requirement is to preclude providers from implementing machine readable data exchange via magnetic tape or other medium with the Medicaid fiscal agent.

Officials of HCFA's Region IX who monitor the State's administration of the Medicaid program believe that conversion to a machine readable data exchange system would prove cost-effective for California. They stated, however, that since Medicaid requirements for MMIS approval do not address machine readable data exchange, Region IX's leverage in dealing with the State is limited. Thus far, Region IX has been unsuccessful in prompting the State to drop its requirement for proof of eligibility labels.

THE MMIS TASK FORCE

Although MMIS guidelines do not currently include specific requirements related to automated billing, HCFA has designated a Task Force to develop new performance standards for States under the program. These standards will be used to periodically reevaluate each State's administration of the Medicaid program and determine whether it should qualify for 75 percent MMIS Federal cost sharing. Those States with an approved MMIS receive Federal reimbursement for 75 percent of their claims processing costs. States without an approved MMIS receive 50 percent sharing for such costs. Through this arrangement, States are given a significant financial incentive to comply with the standards set forth in MMIS guidelines.

CONCLUSIONS

Substantial administrative cost savings by large providers as well as Medicare and Medicaid claims paying agents appear possible through implementation of machine readable data exchange systems. While HCFA has taken action to broaden the implementation of these kinds of systems under Medicare where they are found cost effective, States may need to modify existing program requirements before such systems can become a reality under Medicaid. We believe the situation in California illustrates a need for stronger Federal financial incentives to persuade States to take the needed action.

RECOMMENDATIONS

We recommend that you direct the MMIS Task Force to include the potential benefits of machine readable data exchange as one factor in developing State performance standards relating to the cost and timeliness of processing Medicaid claims. In this way, we believe States will be given a stronger financial incentive to implement this technique where it is found cost effective. In addition, we believe the Task Force should provide guidance to the States on the benefits of automated billing systems and point out how the use of machine readable data exchange can assist in meeting the performance standards which are to be promulgated.

Sincerely yours,

Robert E. Iffert

Robert E. Iffert, Jr.
Assistant Director